

09008

CERTIFICATE OF DEATH

08967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Mt Hermon Rd.)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSHUA Middle SAMPSON Last ADKINS				4. DATE OF DEATH Month August Day 3 rd Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0 Days 11	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D.# 1 Parsonsborg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Joseph James Adkins				14. MOTHER'S MAIDEN NAME Catherine Holloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Annie Freeny Adkins (Wife) R.D.# 1 (Mt Hermon) Parsonsborg, Maryland - Mrs. Louis N. Adkins (Daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 yrs. sign.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1952 19 to 8-3-57 19 that I last saw the deceased alive on 8-2-57 19, and that death occurred at 4:15 P. M. from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE Frank Lewis				ADDRESS (Street, city or town, state) Willards, Maryland			
PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis				Aug. 5 / 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery		22d. LOCATION (City, town, or county) (State) Near Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR AUG 6 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08956

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 8 Film G219 8-19-57 et

08968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville P.F.D. 46 X-3</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELAINE</u> First Middle Last		4. DATE OF DEATH <u>8</u> Month <u>7</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Richard Scott</u>	
14. MOTHER'S MARDEN NAME <u>Adelaide Risks</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>222 20 3590</u>		17. INFORMANT <u>Blanche Warren</u> Address <u>Salisbury Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mult-pl injuries - cerebral concussion -</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fract-pulvis - comp part of tibia - Fract rt femur</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fract-pulvis - comp part of tibia - Fract rt femur</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motor vehicle accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-2-57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>State highway</u>	20f. (City or town) <u>Ocean City, Wicomico, Md</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A Insley</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bishopville</u>		22d. LOCATION (City, town, or county) <u>Bishopville Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson + Gray, Frankford Del</u>		24a. REC'D BY REGISTRAR <u>Mary K. Holloway</u> 24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 12 1957

BUREAU V. 3

09009

CERTIFICATE OF DEATH

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 5 (Glen St.)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle EARL Last ANDERSON				4. DATE OF DEATH Month August Day 31st Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1905		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 6 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John Anderson			14. MOTHER'S MAIDEN NAME Ella Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Virginia Anderson (Wife) Address R.D.# 5 Glen St. Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 54 , to Aug 31 , 19 57 , that I last saw the deceased alive on Aug 30 , 19 57 , and that death occurred at 11:00 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED Aug. 31, 1957							
ACTUAL SIGNATURE Paul M. Beardsley			M.D. Salisbury, Md				
PHYSICIAN'S NAME (Type) Dr. Earl L. Beardsley			Maryland Ave. Salisbury, Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD				24a. REC'D BY REGISTRAR SEP 3 1957			
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08957 CERTIFICATE OF DEATH

08970
337

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>602B Rose St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Brookley</u> Last <u>Brookley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>Johns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>3</u>	
17. INFORMANT <u>Eda Johns</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>AC Dr. Mitchell</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockwell</u>		22d. LOCATION (City, town, or county) (State) <u>Rockwell Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin H. Alford</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u> 24b. REGISTRAR'S SIGNATURE	
DATE <u>AUG 14 1957</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
HASTINGS		45		M		W		1912		BOSTON		MASSACHUSETTS		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
JULY 10, 1957		BOSTON		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL		METHODIST		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CHURCH OFFICIAL	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CAUSE OF REGISTRATION		MANNER OF REGISTRATION		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
AUG 14, 1957		BOSTON		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL		METHODIST		MARRIED	

BUREAU V. E.

AUG 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08958

CERTIFICATE OF DEATH

08972

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN TB <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Albert</u> Last <u>Bosley</u>				4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Henry Bosley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Emma Brothers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>218-09-3682</u>			
17. INFORMANT <u>Hospital Records, Deer's Head State Hospital</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, with decompensation</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus with gangrene of right leg</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic carcinoma of the prostate</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/21/57</u> , 19 <u> </u> , to <u>8/23/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/23/57</u> , 19 <u> </u> , and that death occurred at <u>8:20 a. M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>G. Kosmahly</u>				M.D. <u>Deer's Head State Hospital</u> <u>8/23/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-26-57</u>		<u>Wm Zion</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR			
<u>Edw & Gipton, Hampstead Md</u>				<u> </u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE			
<u> </u>				<u> </u>			

AUG 28 1957

RECEIVED

JUG 28 1957

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08973
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 729 Roger St				d. STREET ADDRESS 729 Roger St			
3. NAME OF DECEASED (Type or print) First JAMES Middle LOUIS Last CAMPBELL				4. DATE OF DEATH Month August Day 9th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1914		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Wicomico Armature Co. (Elec Motors)		10b. KIND OF BUSINESS OR INDUSTRY Pittsville, Maryland		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Handy Campbell				14. MOTHER'S MAIDEN NAME Sallie Rigger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.II		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lorena Rider Campbell (Wife) 729 Roger St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 12 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 12, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR AUG 15 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

STATEMENT OF HEALTH - BIRTH RECORD 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE	
OFFICE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	

BUREAU V. S.

AUG 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08974

338

08960

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. STREET ADDRESS 511 E. Isabella St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle FRANKLIN Last CAREY		4. DATE OF DEATH Month August Day 31 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12, 1873
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meth. Minister		10b. KIND OF BUSINESS OR INDUSTRY Minister	
11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Josiah Carey		14. MOTHER'S MAIDEN NAME Susan Collins Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Blanche Carey Address Camden Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO senility (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year 19 57 o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 52 to Aug 31, 19 57 , that I last saw the deceased alive on Aug 31, 19 57 , and that death occurred at 10:27 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alberta Mattax		DATE SIGNED 9/3/57	
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	22d. LOCATION (City, town, or county) (State) Bishopville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY, MD		24a. REC'D BY REGISTRAR SEP 4 1957	
		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 5 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08961

CERTIFICATE OF DEATH

Reg. Dist. No.

08975338

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>SNOW HILL 23x22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>B.R.2.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lulu</u> Middle <u>W.</u> Last <u>CARMEAN</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22-1879</u>	
9. AGE (In years last birthday) <u>78 1/2</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>	
13. FATHER'S NAME <u>James K. West</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Clifford Duffy, Salisbury, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crownary Artery Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>" " Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Salisbur</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury</u>				DATE SIGNED <u>8 22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Dummis</u>				ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 26 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>							

BUREAU V. S.

AUG 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08962 CERTIFICATE OF DEATH

0897632
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>416 Joplin Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>M.</u> Last <u>Choate</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/7/1911</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alvin Choate</u>			
14. MOTHER'S MAIDEN NAME <u>Addie Snyder</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>213-09-1114</u>			
16. SOCIAL SECURITY NO. <u>213-09-1114</u>				17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>162x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paraplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1/</u> , 19 <u>57</u> , to <u>8/10/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/9/57</u> , 19 <u>57</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>8/10/57</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOORELAND MEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bruce Bradley, Funeral Hg.</u>				24. REC'D BY REGISTRAR DATE <u>AUG 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

CERTIFICATE OF DEATH

8862

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68	
4. DATE OF DEATH August 13, 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. Harris	
10. SIGNATURE OF REGISTRAR J. H. Harris		11. SIGNATURE OF WITNESSES J. H. Harris		12. SIGNATURE OF DECEASED J. H. Harris	

BUREAU V. S.

AUG 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8963

CERTIFICATE OF DEATH

Reg. Dist. No.

08973 ✓

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury X/	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospt.		d. STREET ADDRESS Route # 2 (Spring Hill Road)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carl First Joseph Middle Cosloy Last		4. DATE OF DEATH Month August Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1914.
9. AGE (In years birthday) yrs. 43		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Mechanical	
11. BIRTHPLACE (State or foreign country) Little Falls, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Cosloy		14. MOTHER'S MAIDEN NAME Ann Cosloy Greenstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Jean D. Cosloy (Wife)		Address Route # 2, Salisbury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - massive 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.-V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Aug. 5, 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 5, 1957 to Aug. 5, 1957 , that I last saw the deceased alive on Aug. 5, 1957 , and that death occurred at 12:48 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 8/5/57			
ACTUAL SIGNATURE William D. Gray M.D.		PHYSICIAN'S NAME (Type) William D. Gray M. D. Salisbury, Maryland. Aug. 5, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Laurel Grove Mem. Park		22d. LOCATION (City, town, or county) (State) (Toward) Near Little Falls, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company		ADDRESS Salisbury, Maryland.	
24a. REC'D BY REGISTRAR AUG 8 1957		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08978

08964

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden			
f. STREET ADDRESS R.D.# 1				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle BENJAMIN Last CROUCH				4. DATE OF DEATH Month AUGUST Day 5 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 11 Days 7 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Donstruction			
11. BIRTHPLACE (State or foreign country) Allen Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Henry Crouch				14. MOTHER'S MAIDEN NAME Emma Reddish			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Eva F. Crouch (Wife)				Address R.D.# 1 Eden, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Hypostatic) Pneumonia DUE TO 364X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infectious Polyneuritis DUE TO with Paraplegia (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 3 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 17 Year 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17 , 19 57 , to 8/5 , 19 57 , that I last saw the deceased alive on Aug 5 , 19 57 , and that death occurred at 4:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED Aug. 5, 1957 ACTUAL SIGNATURE David Gilmore M.D. Salisbury Md. PHYSICIAN'S NAME (Type) Dr Gilmore, David Medical Center Salisbury, Md Aug. 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-		22b. DATE THEREOF Aug. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Fruitland Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR AUG 6 1957			
24b. REGISTRAR'S SIGNATURE Maya Holloway							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JAN 15 1892		BALTIMORE		MD		MD		USA	
MARRIAGE		SINGLE		MARRIED		JAN 15 1892		BALTIMORE		MD		MD		USA	
OCCUPATION		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
DATE OF DEATH		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		MD		MD		MD		MD		MD		MD		MD	
COUNTRY		USA		USA		USA		USA		USA		USA		USA	

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08965

CERTIFICATE OF DEATH

0897937

Reg. Dist. No. 261

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>1 yr. 11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Marion, Maryland 19x02</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Dennis</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 2, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Dennis</u>				14. MOTHER'S MAIDEN NAME <u>Judie (unk) Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital records</u> Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> (c) <u>Arteriosclerosis general and cerebral</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 14, 1956</u> , to <u>Aug. 25, 1957</u> , that I last saw the deceased alive on <u>Aug. 25, 1957</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Dr. V. Juerman</u>				DATE SIGNED <u>Aug. 25, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Branch Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marion, SomCo., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George W. Tilghman</u>				ADDRESS <u>Marion Sta</u>		24a. REC'D BY REGISTRAR DATE <u>8/26/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Hellie R. Payne</u> <u>Mary H. Hollings</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 2

AUG 28 1957

RECEIVED

08966

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 418 Liberty Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lloyd Middle Franklin Last Dennis				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 12, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer (Horse Race Track)				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Alton Dennis				14. MOTHER'S MAIDEN NAME Rebecca Dennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Unk.				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Alton W. Dennis (Son)				418 Liberty St. Deer's Head Hospital, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent Cerebrovascular Accident							
INTERVAL BETWEEN ONSET AND DEATH Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 31, 1957 , to Aug. 27, 1957 , that I last saw the deceased alive on August 27, 1957 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/28/57							
ACTUAL SIGNATURE G. Kosmahly				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Deer's Head State Hospital, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.				24. RECD BY REGISTRAR SEP 3		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No.

DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS ILLNESS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PATHOLOGICAL FINDINGS		LABORATORY FINDINGS	
POST-MORTEM FINDINGS		OTHER FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

SEP 3 1957

RECEIVED

08967

CERTIFICATE OF DEATH

0898B31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				e. STREET ADDRESS 207 E. Chestnut St.			
3. NAME OF DECEASED (Type or print) First Ollie Middle Mae Last Disharoon				4. DATE OF DEATH Month August Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (In years last birthday) 65 yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William James Sterling				14. MOTHER'S MAIDEN NAME Rebecca Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. --			
17. INFORMANT Deer's Head State Hospital, Salisbury, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Carcinoma of uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 25 yrs. ? (c) 174x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary anemia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 14, 19 57 to August 23, 19 57 , that I last saw the deceased alive on August 23, 19 57 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/23/57							
ACTUAL SIGNATURE L. V. Maldve				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-57		22c. NAME OF CEMETERY OR CREMATORY Sunny Ridge		22d. LOCATION (City, town, or county) (State) Hopewell, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co. - Delmar, Del.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 27 1957

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		CLOCK MAKER		CLOCK MAKER		ARMY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
JAN 6 1968		MOBILE ALABAMA		HEART DISEASE		NATURAL		JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. 2

JUG 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08968

CERTIFICATE OF DEATH

08982 37

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>22 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>305 Poplar Hill Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Miranda</u> Middle Last <u>Dixon</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 12, 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert Pinkett</u>				14. MOTHER'S MAIDEN NAME <u>Belle Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Thos. Vera White, 305 Poplar Hill Ave, City</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal perineal resection for</u> DUE TO (c) <u>Carcinoma of rectum.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While o. m. Not while p. m. <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fikowich</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>May H. Holloway</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint, illegible text]</p>		<p>2. SEX [Faint, illegible text]</p>	
<p>3. AGE [Faint, illegible text]</p>		<p>4. DATE OF BIRTH [Faint, illegible text]</p>	
<p>5. PLACE OF BIRTH [Faint, illegible text]</p>		<p>6. DATE OF DEATH [Faint, illegible text]</p>	
<p>7. PLACE OF DEATH [Faint, illegible text]</p>		<p>8. CAUSE OF DEATH [Faint, illegible text]</p>	
<p>9. MANNER OF DEATH [Faint, illegible text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint, illegible text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint, illegible text]</p>		<p>12. SIGNATURE OF WITNESS [Faint, illegible text]</p>	

BUREAU V. 1

AUG 27 1957

RECEIVED

08969

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. STREET ADDRESS 321 Barclay St			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WILLIAM Last DRISCOLL				4. DATE OF DEATH Month AUGUST Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1891		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 3 Days 10	IF UNDER 24 HRS Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman (Packing Plant) Employee		10b. KIND OF BUSINESS OR INDUSTRY Delaware		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Driscoll				14. MOTHER'S MAIDEN NAME Martha Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 450.0		17. INFORMANT Mrs. Elva Hardy (Daughter) R.D. #2 Jersey Rd. Lake St. Ext. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho. Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 to 8/19 , 19 57 , that I last saw the deceased alive on 8/19 , 19 57 , and that death occurred at 12:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Aug. 19 1957							
ACTUAL SIGNATURE Dr. Fred R. Gramse				M.D. Salisbury, Md.			
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse				S. Division St. Salisbury, Md. Aug. 19 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR AUG 20 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68	
4. DATE OF DEATH August 18, 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. HARRIS	
10. SIGNATURE OF REGISTRAR J. H. HARRIS		11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF DECEASED J. H. HARRIS	
13. SIGNATURE OF DECEASED J. H. HARRIS		14. SIGNATURE OF DECEASED J. H. HARRIS		15. SIGNATURE OF DECEASED J. H. HARRIS	
16. SIGNATURE OF DECEASED J. H. HARRIS		17. SIGNATURE OF DECEASED J. H. HARRIS		18. SIGNATURE OF DECEASED J. H. HARRIS	
19. SIGNATURE OF DECEASED J. H. HARRIS		20. SIGNATURE OF DECEASED J. H. HARRIS		21. SIGNATURE OF DECEASED J. H. HARRIS	
22. SIGNATURE OF DECEASED J. H. HARRIS		23. SIGNATURE OF DECEASED J. H. HARRIS		24. SIGNATURE OF DECEASED J. H. HARRIS	
25. SIGNATURE OF DECEASED J. H. HARRIS		26. SIGNATURE OF DECEASED J. H. HARRIS		27. SIGNATURE OF DECEASED J. H. HARRIS	
28. SIGNATURE OF DECEASED J. H. HARRIS		29. SIGNATURE OF DECEASED J. H. HARRIS		30. SIGNATURE OF DECEASED J. H. HARRIS	
31. SIGNATURE OF DECEASED J. H. HARRIS		32. SIGNATURE OF DECEASED J. H. HARRIS		33. SIGNATURE OF DECEASED J. H. HARRIS	
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37. SIGNATURE OF DECEASED J. H. HARRIS		38. SIGNATURE OF DECEASED J. H. HARRIS		39. SIGNATURE OF DECEASED J. H. HARRIS	
40. SIGNATURE OF DECEASED J. H. HARRIS		41. SIGNATURE OF DECEASED J. H. HARRIS		42. SIGNATURE OF DECEASED J. H. HARRIS	
43. SIGNATURE OF DECEASED J. H. HARRIS		44. SIGNATURE OF DECEASED J. H. HARRIS		45. SIGNATURE OF DECEASED J. H. HARRIS	
46. SIGNATURE OF DECEASED J. H. HARRIS		47. SIGNATURE OF DECEASED J. H. HARRIS		48. SIGNATURE OF DECEASED J. H. HARRIS	
49. SIGNATURE OF DECEASED J. H. HARRIS		50. SIGNATURE OF DECEASED J. H. HARRIS		51. SIGNATURE OF DECEASED J. H. HARRIS	
52. SIGNATURE OF DECEASED J. H. HARRIS		53. SIGNATURE OF DECEASED J. H. HARRIS		54. SIGNATURE OF DECEASED J. H. HARRIS	
55. SIGNATURE OF DECEASED J. H. HARRIS		56. SIGNATURE OF DECEASED J. H. HARRIS		57. SIGNATURE OF DECEASED J. H. HARRIS	
58. SIGNATURE OF DECEASED J. H. HARRIS		59. SIGNATURE OF DECEASED J. H. HARRIS		60. SIGNATURE OF DECEASED J. H. HARRIS	
61. SIGNATURE OF DECEASED J. H. HARRIS		62. SIGNATURE OF DECEASED J. H. HARRIS		63. SIGNATURE OF DECEASED J. H. HARRIS	
64. SIGNATURE OF DECEASED J. H. HARRIS		65. SIGNATURE OF DECEASED J. H. HARRIS		66. SIGNATURE OF DECEASED J. H. HARRIS	
67. SIGNATURE OF DECEASED J. H. HARRIS		68. SIGNATURE OF DECEASED J. H. HARRIS		69. SIGNATURE OF DECEASED J. H. HARRIS	
70. SIGNATURE OF DECEASED J. H. HARRIS		71. SIGNATURE OF DECEASED J. H. HARRIS		72. SIGNATURE OF DECEASED J. H. HARRIS	
73. SIGNATURE OF DECEASED J. H. HARRIS		74. SIGNATURE OF DECEASED J. H. HARRIS		75. SIGNATURE OF DECEASED J. H. HARRIS	
76. SIGNATURE OF DECEASED J. H. HARRIS		77. SIGNATURE OF DECEASED J. H. HARRIS		78. SIGNATURE OF DECEASED J. H. HARRIS	
79. SIGNATURE OF DECEASED J. H. HARRIS		80. SIGNATURE OF DECEASED J. H. HARRIS		81. SIGNATURE OF DECEASED J. H. HARRIS	
82. SIGNATURE OF DECEASED J. H. HARRIS		83. SIGNATURE OF DECEASED J. H. HARRIS		84. SIGNATURE OF DECEASED J. H. HARRIS	
85. SIGNATURE OF DECEASED J. H. HARRIS		86. SIGNATURE OF DECEASED J. H. HARRIS		87. SIGNATURE OF DECEASED J. H. HARRIS	
88. SIGNATURE OF DECEASED J. H. HARRIS		89. SIGNATURE OF DECEASED J. H. HARRIS		90. SIGNATURE OF DECEASED J. H. HARRIS	
91. SIGNATURE OF DECEASED J. H. HARRIS		92. SIGNATURE OF DECEASED J. H. HARRIS		93. SIGNATURE OF DECEASED J. H. HARRIS	
94. SIGNATURE OF DECEASED J. H. HARRIS		95. SIGNATURE OF DECEASED J. H. HARRIS		96. SIGNATURE OF DECEASED J. H. HARRIS	
97. SIGNATURE OF DECEASED J. H. HARRIS		98. SIGNATURE OF DECEASED J. H. HARRIS		99. SIGNATURE OF DECEASED J. H. HARRIS	
100. SIGNATURE OF DECEASED J. H. HARRIS		101. SIGNATURE OF DECEASED J. H. HARRIS		102. SIGNATURE OF DECEASED J. H. HARRIS	

BUREAU V. 2

AUG 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08970
CERTIFICATE OF DEATH

08984
231

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 19x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.D. # 2 (Rural)</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Dykes</u> Last <u>Dykes</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee-Penna. State Highway Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eden Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Dykes</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shockley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Sarah E. Dykes (Wife)</u>		Address <u>R.D. # 2 Princess Anne, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D.		<u>Medical Center-</u> <u>Aug. 8th, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westmorland Mem. Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greensburg, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERALHOME - SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

RECEIVED

0898731

08971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #10 Camden Ave, Ext.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucy Middle Blose Last Eaton				4. DATE OF DEATH Month Aug. Day 8. Year 1957.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1881.	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work.		11. BIRTHPLACE (State or foreign country) Urbana, Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James JAMES Irvin Blose				14. MOTHER'S MAIDEN NAME Lucy Ann Straw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lucy Ann Hill (Daughter) #10 Camden Ave, Ext. Salisbury, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Accident DUE TO (c) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 36 hours 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2, 1955 to Aug 8, 1957 , that I last saw the deceased alive on August 8, 1957 , and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 224 N. Division St. Salisbury, Maryland DATE SIGNED Aug 9th, 1957							
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.				22a. REC'D BY REGISTRAR Mary H. Holloway			
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Jr.				22b. REGISTRAR'S SIGNATURE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery		22d. LOCATION (City, town, or county) (State) Urbana, Ohio.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland,				24a. REC'D BY REGISTRAR Aug 12 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 12 1957

Form with multiple sections and fields, mostly illegible due to heavy noise and bleed-through. Visible text includes:

- Section 1: [Illegible]
- Section 2: [Illegible]
- Section 3: [Illegible]
- Section 4: [Illegible]
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- Section 6: [Illegible]
- Section 7: [Illegible]
- Section 8: [Illegible]
- Section 9: [Illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08986

08972

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER FAIRMOUNT</u> 19x22			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HANCE</u> <u>FALLON</u>				4. DATE OF DEATH Month Day Year <u>8</u> <u>19</u> <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>		13. FATHER'S NAME <u>JOHN FALLON</u>		14. MOTHER'S MAIDEN NAME <u>ZIPPIE COLINS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>JACK R. FALLON NEW HAVEN, CONN.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart & Arteries</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/16</u> , 19 <u>57</u> to <u>8/19</u> , 19 <u>57</u> that I last saw the deceased alive on <u>8/19/57</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William H. James Jr</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. CARRELL HEARN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8/25/57</u>		<u>BOGGS</u>		<u>UPPER HILL, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR PRINCESS ANNE, MD</u>				24a. REC'D BY REGISTRAR DATE <u>8-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

RECEIVED

AUG 26 1957

BUREAU V. 2

RECEIVED		AUG 26 1957		BUREAU V. 2	
MARYLAND STATE DEPARTMENT OF HEALTH - BATHING 19					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED					
2. SEX					
3. AGE					
4. DATE OF BIRTH					
5. PLACE OF BIRTH					
6. OCCUPATION					
7. CAUSE OF DEATH					
8. PLACE OF DEATH					
9. TIME OF DEATH					
10. SIGNATURE OF DECEASED					
11. SIGNATURE OF WITNESS					
12. SIGNATURE OF PHYSICIAN					
13. SIGNATURE OF CORONER					
14. SIGNATURE OF JURY					
15. SIGNATURE OF JUDGE					
16. SIGNATURE OF CLERK					
17. SIGNATURE OF NOTARY					
18. SIGNATURE OF SHERIFF					
19. SIGNATURE OF DEPUTY SHERIFF					
20. SIGNATURE OF CONSTABLE					
21. SIGNATURE OF JAILER					
22. SIGNATURE OF PRISONER					
23. SIGNATURE OF GUARD					
24. SIGNATURE OF WARDEN					
25. SIGNATURE OF CHIEF OF POLICE					
26. SIGNATURE OF DETECTIVE					
27. SIGNATURE OF OFFICER					
28. SIGNATURE OF SERGEANT					
29. SIGNATURE OF CAPTAIN					
30. SIGNATURE OF MAJOR					
31. SIGNATURE OF LIEUTENANT					
32. SIGNATURE OF PRIVATE					
33. SIGNATURE OF SQUAD LEADER					
34. SIGNATURE OF PLATOON LEADER					
35. SIGNATURE OF COMPANY COMMANDER					
36. SIGNATURE OF BATTALION COMMANDER					
37. SIGNATURE OF REGIMENT COMMANDER					
38. SIGNATURE OF BRIGADE COMMANDER					
39. SIGNATURE OF DIVISION COMMANDER					
40. SIGNATURE OF CORPS COMMANDER					
41. SIGNATURE OF ARMY COMMANDER					
42. SIGNATURE OF NAVY COMMANDER					
43. SIGNATURE OF AIR FORCE COMMANDER					
44. SIGNATURE OF MARINE COMMANDER					
45. SIGNATURE OF COAST GUARD COMMANDER					
46. SIGNATURE OF CUSTOMS COMMANDER					
47. SIGNATURE OF BORDER PATROL COMMANDER					
48. SIGNATURE OF INSPECTION COMMANDER					
49. SIGNATURE OF INVESTIGATION COMMANDER					
50. SIGNATURE OF PROSECUTION COMMANDER					
51. SIGNATURE OF DEFENSE COMMANDER					
52. SIGNATURE OF JURY COMMANDER					
53. SIGNATURE OF JUDGE COMMANDER					
54. SIGNATURE OF CLERK COMMANDER					
55. SIGNATURE OF NOTARY COMMANDER					
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57. SIGNATURE OF DEPUTY SHERIFF COMMANDER					
58. SIGNATURE OF CONSTABLE COMMANDER					
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60. SIGNATURE OF PRISONER COMMANDER					
61. SIGNATURE OF GUARD COMMANDER					
62. SIGNATURE OF WARDEN COMMANDER					
63. SIGNATURE OF CHIEF OF POLICE COMMANDER					
64. SIGNATURE OF DETECTIVE COMMANDER					
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71. SIGNATURE OF SQUAD LEADER COMMANDER					
72. SIGNATURE OF PLATOON LEADER COMMANDER					
73. SIGNATURE OF COMPANY COMMANDER COMMANDER					
74. SIGNATURE OF BATTALION COMMANDER COMMANDER					
75. SIGNATURE OF REGIMENT COMMANDER COMMANDER					
76. SIGNATURE OF BRIGADE COMMANDER COMMANDER					
77. SIGNATURE OF DIVISION COMMANDER COMMANDER					
78. SIGNATURE OF CORPS COMMANDER COMMANDER					
79. SIGNATURE OF ARMY COMMANDER COMMANDER					
80. SIGNATURE OF NAVY COMMANDER COMMANDER					
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87. SIGNATURE OF INVESTIGATION COMMANDER COMMANDER					
88. SIGNATURE OF PROSECUTION COMMANDER COMMANDER					
89. SIGNATURE OF DEFENSE COMMANDER COMMANDER					
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97. SIGNATURE OF JAILER COMMANDER COMMANDER					
98. SIGNATURE OF PRISONER COMMANDER COMMANDER					
99. SIGNATURE OF GUARD COMMANDER COMMANDER					
100. SIGNATURE OF WARDEN COMMANDER COMMANDER					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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08973

CERTIFICATE OF DEATH

08987

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Swan Harbor	
3. NAME OF DECEASED (Type or print) First Anna Middle Catherine Last Fell		4. DATE OF DEATH Month August Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1912
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kulpa		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioma of brain, inoperable DUE TO 193x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22, 1957 , to Aug. 23, 1957 , that I last saw the deceased alive on August 23, 1957 , and that death occurred at 11:20PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. V. Juerman M.D.		ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/24/57	
PHYSICIAN'S NAME (Type) V. Juerman, M.D.		Deer's Head State Hospital, Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/57	
22c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem.		22d. LOCATION (City, town, or county) (State) Havre de Grace Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Will Johnson Co. Salisbury ADDRESS Franklin B. Hill		24a. REC'D BY REGISTRAR 8/26/57 24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

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AUG 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 1011 E. Church St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle RUSSELL Last FURNESS				4. DATE OF DEATH Month AUGUST Day 27 th Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1908		9. AGE (In years lost birthday) 49 yrs.	IF UNDER 1 YEAR Months 0 Days 2 Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-Service Station				10b. KIND OF BUSINESS OR INDUSTRY Filling Station		11. BIRTHPLACE (State or foreign country) Saxis Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Sidney Otto Furness				14. MOTHER'S MAIDEN NAME Mary A. Justice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Barbara Lee Tilghman (Daughter)				Address 1011 E. Church St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Lymphosarcoma abdomen 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/29 , 19 57 , to 8/27 , 19 57 , that I last saw the deceased alive on 8/27 , 19 57 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland DATE SIGNED 8/28/57							
ACTUAL SIGNATURE Dr. Andrew C. Mitchell				M.D. 211 Maryland Ave			
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				Maryland Ave. Salisbury, Md. Aug. 28 /57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE			
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 3 1957

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		NAME OF PHYSICIAN _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____	
NAME OF REGISTRAR _____		NAME OF CLERK _____	

RECEIVED
 SEP 3 1957
 BUREAU V. 1

08975

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospt.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Smallwood Last Goff				4. DATE OF DEATH Month Aug. Day 22. Year 1957.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15. 1871.		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 8 Days 7 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home.		11. BIRTHPLACE (State or foreign country) Cold Spring N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Corgie Town				14. MOTHER'S MAIDEN NAME George Emma Eldredge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Henrietta G. Smith (Daughter) Address Route #3 Salisbury, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Atherosclerosis DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 24, 1957 to Aug 22, 1957 , that I last saw the deceased alive on Aug 22, 1957 , and that death occurred at 11.45a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Alberta Mattax				M.D. 211 Pasadena Ave., Salisbury DATE SIGNED 8/24/57			
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax				Salisbury, Maryland.			
22a. BURIAL, CREMATION, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		Aug. 27. 57.		Cold Spring Cemetery.		Cold Spring N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.				24a. REC'D BY REGISTRAR DATE AUG 27 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08

Aug 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09010

CERTIFICATE OF DEATH

08990 325

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 25 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cemetery Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herman Middle Clarence Last Henry				4. DATE OF DEATH Month Aug. Day 30 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1883 (2)	
9. AGE (In years last birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Dorchester County, Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Henry		14. MOTHER'S MAIDEN NAME Willie Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-4084		17. INFORMANT Maggie Henry, Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Discrete Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease (c) 260x							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/1 , 19 55 , to 8/30 , 19 57 , that I last saw the deceased alive on 8/30/57 , 19 57 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharptown, Md. DATE SIGNED Charles M. Moyer							
ACTUAL SIGNATURE Charles M. Moyer M.D.				PHYSICIAN'S NAME (Type) Charles M. Moyer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-1957		22c. NAME OF CEMETERY OR CREMATORY Firemans		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles M. Moyer, Sharptown, Md.				24a. REC'D BY REGISTRAR Mary Owens		24b. REGISTRAR'S SIGNATURE Mary Owens	

SEP 4 1957

09011

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLARDS</u>				c. LENGTH OF STAY IN 1b <u>X2 WILLARDS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATIE DELLA HICKMAN</u>				4. DATE OF DEATH Month Day Year <u>AUG 4 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 29, 1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTH PLACE (State or foreign country) <u>BERLIN MD. RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMPSON TRUITT</u>				14. MOTHER'S MAIDEN NAME <u>ALICE POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MARILLOYD HICKMAN, WILLARDS, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis</u> <u>431X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renovated arthritis (united in 18)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3-4 weeks</u> <u>18 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> , 19 <u>57</u> , to <u>8-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 4</u> , 19 <u>57</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank R. Lewis</u>				DATE SIGNED <u>Willards Maryland 8-6-57</u>			
PHYSICIAN'S NAME (Type) <u>FRANK R. LEWIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WILLARDS</u>		22d. LOCATION (City, town, or county) (State) <u>WILLARDS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Purbye Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. PLACE OF DEATH <i>Home</i>		10. TIME OF DEATH <i>10:30 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		14. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
15. SIGNATURE OF CLERGYMAN <i>John Doe</i>		16. SIGNATURE OF OTHER <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF OTHER <i>John Doe</i>	
19. SIGNATURE OF OTHER <i>John Doe</i>		20. SIGNATURE OF OTHER <i>John Doe</i>	
21. SIGNATURE OF OTHER <i>John Doe</i>		22. SIGNATURE OF OTHER <i>John Doe</i>	
23. SIGNATURE OF OTHER <i>John Doe</i>		24. SIGNATURE OF OTHER <i>John Doe</i>	
25. SIGNATURE OF OTHER <i>John Doe</i>		26. SIGNATURE OF OTHER <i>John Doe</i>	
27. SIGNATURE OF OTHER <i>John Doe</i>		28. SIGNATURE OF OTHER <i>John Doe</i>	
29. SIGNATURE OF OTHER <i>John Doe</i>		30. SIGNATURE OF OTHER <i>John Doe</i>	
31. SIGNATURE OF OTHER <i>John Doe</i>		32. SIGNATURE OF OTHER <i>John Doe</i>	
33. SIGNATURE OF OTHER <i>John Doe</i>		34. SIGNATURE OF OTHER <i>John Doe</i>	
35. SIGNATURE OF OTHER <i>John Doe</i>		36. SIGNATURE OF OTHER <i>John Doe</i>	
37. SIGNATURE OF OTHER <i>John Doe</i>		38. SIGNATURE OF OTHER <i>John Doe</i>	
39. SIGNATURE OF OTHER <i>John Doe</i>		40. SIGNATURE OF OTHER <i>John Doe</i>	
41. SIGNATURE OF OTHER <i>John Doe</i>		42. SIGNATURE OF OTHER <i>John Doe</i>	
43. SIGNATURE OF OTHER <i>John Doe</i>		44. SIGNATURE OF OTHER <i>John Doe</i>	
45. SIGNATURE OF OTHER <i>John Doe</i>		46. SIGNATURE OF OTHER <i>John Doe</i>	
47. SIGNATURE OF OTHER <i>John Doe</i>		48. SIGNATURE OF OTHER <i>John Doe</i>	
49. SIGNATURE OF OTHER <i>John Doe</i>		50. SIGNATURE OF OTHER <i>John Doe</i>	
51. SIGNATURE OF OTHER <i>John Doe</i>		52. SIGNATURE OF OTHER <i>John Doe</i>	
53. SIGNATURE OF OTHER <i>John Doe</i>		54. SIGNATURE OF OTHER <i>John Doe</i>	
55. SIGNATURE OF OTHER <i>John Doe</i>		56. SIGNATURE OF OTHER <i>John Doe</i>	
57. SIGNATURE OF OTHER <i>John Doe</i>		58. SIGNATURE OF OTHER <i>John Doe</i>	
59. SIGNATURE OF OTHER <i>John Doe</i>		60. SIGNATURE OF OTHER <i>John Doe</i>	
61. SIGNATURE OF OTHER <i>John Doe</i>		62. SIGNATURE OF OTHER <i>John Doe</i>	
63. SIGNATURE OF OTHER <i>John Doe</i>		64. SIGNATURE OF OTHER <i>John Doe</i>	
65. SIGNATURE OF OTHER <i>John Doe</i>		66. SIGNATURE OF OTHER <i>John Doe</i>	
67. SIGNATURE OF OTHER <i>John Doe</i>		68. SIGNATURE OF OTHER <i>John Doe</i>	
69. SIGNATURE OF OTHER <i>John Doe</i>		70. SIGNATURE OF OTHER <i>John Doe</i>	
71. SIGNATURE OF OTHER <i>John Doe</i>		72. SIGNATURE OF OTHER <i>John Doe</i>	
73. SIGNATURE OF OTHER <i>John Doe</i>		74. SIGNATURE OF OTHER <i>John Doe</i>	
75. SIGNATURE OF OTHER <i>John Doe</i>		76. SIGNATURE OF OTHER <i>John Doe</i>	
77. SIGNATURE OF OTHER <i>John Doe</i>		78. SIGNATURE OF OTHER <i>John Doe</i>	
79. SIGNATURE OF OTHER <i>John Doe</i>		80. SIGNATURE OF OTHER <i>John Doe</i>	
81. SIGNATURE OF OTHER <i>John Doe</i>		82. SIGNATURE OF OTHER <i>John Doe</i>	
83. SIGNATURE OF OTHER <i>John Doe</i>		84. SIGNATURE OF OTHER <i>John Doe</i>	
85. SIGNATURE OF OTHER <i>John Doe</i>		86. SIGNATURE OF OTHER <i>John Doe</i>	
87. SIGNATURE OF OTHER <i>John Doe</i>		88. SIGNATURE OF OTHER <i>John Doe</i>	
89. SIGNATURE OF OTHER <i>John Doe</i>		90. SIGNATURE OF OTHER <i>John Doe</i>	
91. SIGNATURE OF OTHER <i>John Doe</i>		92. SIGNATURE OF OTHER <i>John Doe</i>	
93. SIGNATURE OF OTHER <i>John Doe</i>		94. SIGNATURE OF OTHER <i>John Doe</i>	
95. SIGNATURE OF OTHER <i>John Doe</i>		96. SIGNATURE OF OTHER <i>John Doe</i>	
97. SIGNATURE OF OTHER <i>John Doe</i>		98. SIGNATURE OF OTHER <i>John Doe</i>	
99. SIGNATURE OF OTHER <i>John Doe</i>		100. SIGNATURE OF OTHER <i>John Doe</i>	

RECEIVED
AUG 8 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08992

08976

CERTIFICATE OF DEATH

Reg. Dist. No.

33✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u> 46 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>RR #1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 24, 1957</u>
9. AGE (In years lost birthday) yrs. <u>33</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Casher Hitchens</u>		14. MOTHER'S MAIDEN NAME <u>Ingeborg Kluge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Casher Hitchens, Selbyville, Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Bronchopneumonia</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal Bacteremia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>33 hrs</u> <u>33 hrs plus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 24, 1957</u> , to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>August 25, 1957</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Sanderson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>916 N. Division St</u> <u>8/25/57</u> <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary A. Holloway</u>	

208 252 XV7

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
JAMES EARL RAY		5-12-42		6-28-68	
PLACE OF BIRTH		MARRIAGE		DATE OF MARRIAGE	
MOBILE, ALABAMA		MAY 1968		MAY 1968	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
ATTORNEY		HEART DISEASE		NATURAL	
FATHER'S NAME		MOTHER'S NAME		PLACE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		MOBILE, ALABAMA	
DATE OF INTERVIEW		DATE OF DEATH		DATE OF BURIAL	
JULY 1, 1968		JULY 1, 1968		JULY 1, 1968	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JULY 1, 1968		JULY 1, 1968		JULY 1, 1968	

RECEIVED
AUG 27 1967
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
ISM 9/55

STATE OF MARYLAND—BALTIMORE, 18

08977

Item 2 Film G220 9-11-57 et

CERTIFICATE OF DEATH

08993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastville 85X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				d. STREET ADDRESS ---			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Eva B. Holland				4. DATE OF DEATH Month Day Year August 29 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1875	
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Christian Wertenbacher Vandegrift				14. MOTHER'S MAIDEN NAME Frances King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT William W. Holland, Jr.				Address Eastville, Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Cardiovascular Renal Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1957 to Aug. 29, 1957 , that I last saw the deceased alive on Aug. 28, 1957 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED 8/30/57							
ACTUAL SIGNATURE Philip A. Insley M.D.							
PHYSICIAN'S NAME (Type) Philip A. Insley				Main St. Salisbury, Md August 30th, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 9-1-1957		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE For James Eastville				ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 4 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 10

1. NAME OF DECEASED Johnnie Mae Williams		2. SEX Female		3. AGE 29	
4. DATE OF DEATH July 17, 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN Dr. J. H. Smith	
10. SIGNATURE OF REGISTRAR Johnnie Mae Williams		11. SIGNATURE OF WITNESSES Johnnie Mae Williams		12. SIGNATURE OF DECEASED Johnnie Mae Williams	
13. SIGNATURE OF DECEASED Johnnie Mae Williams		14. SIGNATURE OF DECEASED Johnnie Mae Williams		15. SIGNATURE OF DECEASED Johnnie Mae Williams	
16. SIGNATURE OF DECEASED Johnnie Mae Williams		17. SIGNATURE OF DECEASED Johnnie Mae Williams		18. SIGNATURE OF DECEASED Johnnie Mae Williams	
19. SIGNATURE OF DECEASED Johnnie Mae Williams		20. SIGNATURE OF DECEASED Johnnie Mae Williams		21. SIGNATURE OF DECEASED Johnnie Mae Williams	
22. SIGNATURE OF DECEASED Johnnie Mae Williams		23. SIGNATURE OF DECEASED Johnnie Mae Williams		24. SIGNATURE OF DECEASED Johnnie Mae Williams	
25. SIGNATURE OF DECEASED Johnnie Mae Williams		26. SIGNATURE OF DECEASED Johnnie Mae Williams		27. SIGNATURE OF DECEASED Johnnie Mae Williams	
28. SIGNATURE OF DECEASED Johnnie Mae Williams		29. SIGNATURE OF DECEASED Johnnie Mae Williams		30. SIGNATURE OF DECEASED Johnnie Mae Williams	
31. SIGNATURE OF DECEASED Johnnie Mae Williams		32. SIGNATURE OF DECEASED Johnnie Mae Williams		33. SIGNATURE OF DECEASED Johnnie Mae Williams	
34. SIGNATURE OF DECEASED Johnnie Mae Williams		35. SIGNATURE OF DECEASED Johnnie Mae Williams		36. SIGNATURE OF DECEASED Johnnie Mae Williams	
37. SIGNATURE OF DECEASED Johnnie Mae Williams		38. SIGNATURE OF DECEASED Johnnie Mae Williams		39. SIGNATURE OF DECEASED Johnnie Mae Williams	
40. SIGNATURE OF DECEASED Johnnie Mae Williams		41. SIGNATURE OF DECEASED Johnnie Mae Williams		42. SIGNATURE OF DECEASED Johnnie Mae Williams	
43. SIGNATURE OF DECEASED Johnnie Mae Williams		44. SIGNATURE OF DECEASED Johnnie Mae Williams		45. SIGNATURE OF DECEASED Johnnie Mae Williams	
46. SIGNATURE OF DECEASED Johnnie Mae Williams		47. SIGNATURE OF DECEASED Johnnie Mae Williams		48. SIGNATURE OF DECEASED Johnnie Mae Williams	
49. SIGNATURE OF DECEASED Johnnie Mae Williams		50. SIGNATURE OF DECEASED Johnnie Mae Williams		51. SIGNATURE OF DECEASED Johnnie Mae Williams	
52. SIGNATURE OF DECEASED Johnnie Mae Williams		53. SIGNATURE OF DECEASED Johnnie Mae Williams		54. SIGNATURE OF DECEASED Johnnie Mae Williams	
55. SIGNATURE OF DECEASED Johnnie Mae Williams		56. SIGNATURE OF DECEASED Johnnie Mae Williams		57. SIGNATURE OF DECEASED Johnnie Mae Williams	
58. SIGNATURE OF DECEASED Johnnie Mae Williams		59. SIGNATURE OF DECEASED Johnnie Mae Williams		60. SIGNATURE OF DECEASED Johnnie Mae Williams	
61. SIGNATURE OF DECEASED Johnnie Mae Williams		62. SIGNATURE OF DECEASED Johnnie Mae Williams		63. SIGNATURE OF DECEASED Johnnie Mae Williams	
64. SIGNATURE OF DECEASED Johnnie Mae Williams		65. SIGNATURE OF DECEASED Johnnie Mae Williams		66. SIGNATURE OF DECEASED Johnnie Mae Williams	
67. SIGNATURE OF DECEASED Johnnie Mae Williams		68. SIGNATURE OF DECEASED Johnnie Mae Williams		69. SIGNATURE OF DECEASED Johnnie Mae Williams	
70. SIGNATURE OF DECEASED Johnnie Mae Williams		71. SIGNATURE OF DECEASED Johnnie Mae Williams		72. SIGNATURE OF DECEASED Johnnie Mae Williams	
73. SIGNATURE OF DECEASED Johnnie Mae Williams		74. SIGNATURE OF DECEASED Johnnie Mae Williams		75. SIGNATURE OF DECEASED Johnnie Mae Williams	
76. SIGNATURE OF DECEASED Johnnie Mae Williams		77. SIGNATURE OF DECEASED Johnnie Mae Williams		78. SIGNATURE OF DECEASED Johnnie Mae Williams	
79. SIGNATURE OF DECEASED Johnnie Mae Williams		80. SIGNATURE OF DECEASED Johnnie Mae Williams		81. SIGNATURE OF DECEASED Johnnie Mae Williams	
82. SIGNATURE OF DECEASED Johnnie Mae Williams		83. SIGNATURE OF DECEASED Johnnie Mae Williams		84. SIGNATURE OF DECEASED Johnnie Mae Williams	
85. SIGNATURE OF DECEASED Johnnie Mae Williams		86. SIGNATURE OF DECEASED Johnnie Mae Williams		87. SIGNATURE OF DECEASED Johnnie Mae Williams	
88. SIGNATURE OF DECEASED Johnnie Mae Williams		89. SIGNATURE OF DECEASED Johnnie Mae Williams		90. SIGNATURE OF DECEASED Johnnie Mae Williams	
91. SIGNATURE OF DECEASED Johnnie Mae Williams		92. SIGNATURE OF DECEASED Johnnie Mae Williams		93. SIGNATURE OF DECEASED Johnnie Mae Williams	
94. SIGNATURE OF DECEASED Johnnie Mae Williams		95. SIGNATURE OF DECEASED Johnnie Mae Williams		96. SIGNATURE OF DECEASED Johnnie Mae Williams	
97. SIGNATURE OF DECEASED Johnnie Mae Williams		98. SIGNATURE OF DECEASED Johnnie Mae Williams		99. SIGNATURE OF DECEASED Johnnie Mae Williams	
100. SIGNATURE OF DECEASED Johnnie Mae Williams		101. SIGNATURE OF DECEASED Johnnie Mae Williams		102. SIGNATURE OF DECEASED Johnnie Mae Williams	

MINUTE 2111-11-11-11

BUREAU V. 2

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08978
CERTIFICATE OF DEATH

08994
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u> 19X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Jr.</u> Last <u>Hopkins</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1878</u>	9. AGE (In years last birthday) <u>79</u> yr.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>
13. FATHER'S NAME <u>John T Hopkins</u>			14. MOTHER'S MAIDEN NAME <u>Julia Webster</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Howard Hopkins</u> Address <u>Wt. Vernon Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hiatus Hernia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Aug 12</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>Aug. 19, 1957</u>					
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.					
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial Aug</u>		<u>1957</u>		<u>Parsons Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Luman</u>		ADDRESS <u>Princess Anne</u>		24a. RECEIVED BY REGISTRAR DATE <u>AUG 23 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>					

AUG 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08995

Reg. Dist. No.

08979

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>#9 NANTICOKE ANNEX</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID JOSEPH KONSTANZER</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 22 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 20, 1957</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSEPH L. KONSTANZER</u>				14. MOTHER'S MAIDEN NAME <u>SARA YOUNG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>JOS. L. KONSTANZER SEAFORD, DELAWARE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxia</u> DUE TO (c) <u>Aspiration of Mucus into Trachea</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>12 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>August 20, 1957</u> , to <u>August 22, 1957</u> , that I last saw the deceased alive on <u>8/22</u> , 1957, and that death occurred at <u>1:19 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. <u>Salisbury, Md</u>				<u>8/22/57</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MORGAN</u>				<u>SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LADY LOUDERS R.C. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SEAFORD, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson</u>				ADDRESS <u>SEAFORD, DEL.</u>		24a. REC'D BY REGISTRAR <u>Aug 26 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

2082282XV3

RECEIVED

08996

CERTIFICATE OF DEATH

Reg. Dist. No.

332

08980

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>303 New York Ave.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALDA</u> Middle <u>GRACE</u> Last <u>LACEY</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		IF UNDER 24 HRS. Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Moore</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Nowell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles Lacey, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma neck.</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-5-57</u> to <u>8-5-57</u> , that I last saw the deceased alive on <u>8-5-57</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.				DATE SIGNED <u>Salisbury Md 8-6-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley 116 East Main St., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Therrell & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>Norman T. Baker</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

MEDICAL CERTIFICATION

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-58

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08981

CERTIFICATE OF DEATH

Reg. Dist. No.

089933✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XIMARDELIA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rita</u> First Middle Last <u>(LALAHOS) LALAHAS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unk</u>	
9. AGE (If years lost birth day) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work - Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>La.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Bernard</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Luke Lalaho (Husband) R.D. # 1 (Athol) Mardela, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized CARCINOMATOSIS</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>OVARIAN CARCINOMA</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>7-13</u> —, 19 <u>57</u> , to <u>8-8</u> —, 19 <u>57</u> , that I last saw the deceased alive on <u>8-7</u> —, 19 <u>57</u> , and that death occurred at <u>10:20</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u> </u>				DATE SIGNED <u>Aug. 8, 1957</u>			
ACTUAL SIGNATURE <u>Robert Lee Baker</u> M.D. Medical Center Salisbury, Md							
PHYSICIAN'S NAME (Type) <u>Dr. Robert Lee Baker</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR <u>Aug 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

RECEIVED

08982

CERTIFICATE OF DEATH

08998

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>RFD # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>F.</u> Last <u>LARE</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 4, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENN. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lare</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Reigner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-05-3094</u>	
17. INFORMANT <u>MRS. B. F. LARE</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>ten minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>8/31/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burby</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1957</u>	
ADDRESS <u>Berlin Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 4 1957

RECEIVED

08983

CERTIFICATE OF DEATH

08999 237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford</u> <u>46 X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Thatcher St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Judy</u> Middle <u>Ann</u> Last <u>Lynch</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1957</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTH PLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carlton Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Norma Lee Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Carlton Lynch</u> Address <u>Salisbury Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac dilatation and failure</u> 754.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart disease, cyanotic type</u> DUE TO (c) <u>Aortic atresia with hypoplastic left ventricle</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>29 Aug</u> , 1957, that I last saw the deceased alive on <u>29 Aug</u> , 1957, and that death occurred at <u>3:05</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. Henderson</u> M.D.		ADDRESS (Street, city or town, state) <u>926 Division St Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u></u>		DATE SIGNED <u>8/30/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 30, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reposa</u>	22d. LOCATION (City, town, or county) (State) <u>Reposa Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u> ADDRESS <u>Frankford Delaware</u>		24a. REC'D BY REGISTRAR <u>SEP 3 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES		37		M		W		SEP 3 1957		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		12345		67890	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
SEP 3 1920		BALTIMORE, MD		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	
SEP 3 1957		BALTIMORE, MD		HEART DISEASE		NATURAL		12345		67890	

RECEIVED
SEP 3 1957
BUREAU V. 1

08984

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOWER FAIRMOUNT 19X1.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Box 11</u>			
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>N.</u> Last <u>Maddox</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 18, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANNING</u>		11. BIRTHPLACE (State or foreign country) <u>OXFORD, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES NICHOLS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-7867</u>		17. INFORMANT Address <u>Arthur Maddox, Fairmount, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Aug 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 31</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alberta Mattax</u> M.D. <u>711 Camden Ave, Salisbury 9/2/57</u>				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>ALBERTA MATTAX, M.D. - 711 CAMDEN AVE. SALISBURY, MD</u>				22a. REC'D BY REGISTRAR <u>9-16-57</u>			
22b. DATE THEREOF <u>9-3-57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Centennial Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Fairmount, Maryland</u>				22e. REGISTRAR'S SIGNATURE <u>Marj W. Holloway</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw + Sons, Crisfield, Md.</u>				24. ADDRESS _____			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page One of Two

General Information

White Males

BUREAU V. S.

SEP 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08985

CERTIFICATE OF DEATH

09000332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 W. Philadelphia Ave.,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GLENN GRICE MEZICK</u>				4. DATE OF DEATH Month Day Year <u>8 26 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mail Carrier Rural</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mail</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Emery Mezick</u>				14. MOTHER'S MAIDEN NAME <u>Julia Dickerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Bessie Mezick, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular accident</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>William H. Fisher, Jr.</u> M.D. <u>Salisbury, Maryland</u> <u>8/26/1957</u> PHYSICIAN'S NAME (Type) <u>Dr. William H. Fisher, Jr. Medical Center Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Robertson's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Trinty, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>8-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Norman F. Baker</u>	

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
C9012 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09001
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. LENGTH OF STAY IN 1b X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		d. STREET ADDRESS 1 In Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SHOCKLEY Last MILLS		4. DATE OF DEATH Month AUGUST Day 4 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 August 22, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Construction Work) Builder		10b. KIND OF BUSINESS OR INDUSTRY Worcester Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John H. Mills		14. MOTHER'S MAIDEN NAME Gertrude Shockley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Informant	
17. INFORMANT Mrs. Berlie M. Mills (Wife)		Address Parsonsborg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Congestive heart failure DUE TO Chronic Pulmonary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c) Emphysema INTERVAL BETWEEN ONSET AND DEATH 1 mo. 3 yrs. 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 to Aug 4 1957 that I last saw the deceased alive on Aug 4 1957 and that death occurred at 10:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Earl M. Beardsley		M.D.	
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley		Md. Ave. Salisbury, Maryland August 5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 7, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery	22d. LOCATION [City, town, or county] (State) Parsonsborg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REC'D BY REGISTRAR Aug 6 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED'S SEX

DECEASED'S AGE

DECEASED'S RACE

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S MARRIAGE STATUS

DECEASED'S OCCUPATION

DECEASED'S EDUCATION

DECEASED'S RELIGION

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S MARITAL HISTORY

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT PHONE NUMBER

DECEASED'S PRESENT EMPLOYER

DECEASED'S PRESENT STATUS

DECEASED'S PRESENT RESIDENCE

DECEASED'S PRESENT OCCUPATION

DECEASED'S PRESENT RELIGION

DECEASED'S PRESENT SOCIAL SECURITY NUMBER

DECEASED'S PRESENT MARITAL HISTORY

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT PHONE NUMBER

DECEASED'S PRESENT EMPLOYER

DECEASED'S PRESENT STATUS

DECEASED'S PRESENT RESIDENCE

DECEASED'S PRESENT OCCUPATION

DECEASED'S PRESENT RELIGION

DECEASED'S PRESENT SOCIAL SECURITY NUMBER

DECEASED'S PRESENT MARITAL HISTORY

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT PHONE NUMBER

DECEASED'S PRESENT EMPLOYER

DECEASED'S PRESENT STATUS

DECEASED'S PRESENT RESIDENCE

DECEASED'S PRESENT OCCUPATION

DECEASED'S PRESENT RELIGION

DECEASED'S PRESENT SOCIAL SECURITY NUMBER

DECEASED'S PRESENT MARITAL HISTORY

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT PHONE NUMBER

DECEASED'S PRESENT EMPLOYER

DECEASED'S PRESENT STATUS

DECEASED'S PRESENT RESIDENCE

DECEASED'S PRESENT OCCUPATION

DECEASED'S PRESENT RELIGION

DECEASED'S PRESENT SOCIAL SECURITY NUMBER

DECEASED'S PRESENT MARITAL HISTORY

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT PHONE NUMBER

DECEASED'S PRESENT EMPLOYER

BUREAU V. S.

AUG 6 1957

RECEIVED

08986

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 928 W. Isabella St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GOLDIE Middle MAE Last MITCHELL				4. DATE OF DEATH Month AUGUST Day 17 Year th 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 4 Days 28	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fairmount, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Daniel Edward Walker				14. MOTHER'S MAIDEN NAME Frances Elizabeth Miles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mr. Lemuel Brown (Son) 928 W. Isabella St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Generalized Carcinomatosis DUE TO Metastatic Carcinoma of Adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Cervix DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. 19 p. m. 	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 1949 to AUG. 16, 1957 that I last saw the deceased alive on AUG. 16, 1957 and that death occurred at 4:12 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley			ADDRESS (Street, city or town, state) 116 E. MAIN St. Salisbury, Md. DATE SIGNED 8/19/57				
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley			Main St. Salisbury, Maryland Aug. 19 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD			24a. REC'D BY REGISTRAR AUG 20 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1957

PLACE OF DEATH		COUNTY	
HARRIS		HARRIS	
CITY OF HOUSTON		CITY OF HOUSTON	
STREET		STREET	
APARTMENT		APARTMENT	
ZIP CODE		ZIP CODE	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
MARRIAGE		MARRIAGE	
RELIGION		RELIGION	
BIRTH		BIRTH	
DEATH		DEATH	
BURIAL		BURIAL	
CREMATION		CREMATION	
INTERMENT		INTERMENT	
FUNERAL		FUNERAL	
COST		COST	
REMARKS		REMARKS	

BUREAU V. 3

AUG 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09003

CERTIFICATE OF DEATH

Reg. Dist. No.

332

08987

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>40 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ocean City Rd.,</u>				d. STREET ADDRESS <u>Ocean City Rd.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MADORA</u> Middle <u>PHILLIPS</u> Last <u>MORRIS</u>			4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>19 57</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1874</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Major Lemuel Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Bell Wimbrow</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Linwood Morris, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>25 mins.</u> <u>Years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-31</u> , 19 <u>55</u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>8-17</u> , 19 <u>57</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u> </u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>Dr. O.J. Burton 211 Maryland Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u> <u>Norman F. Baker</u>				24a. REC'D BY REGISTRAR DATE <u>8-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-21-21		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School	
11. DECEASED AT Baltimore, Md.		12. DECEASED ON 6-6-68		13. DECEASED AT Home		14. DECEASED AT Home		15. DECEASED AT Home	
16. DECEASED AT Home		17. DECEASED AT Home		18. DECEASED AT Home		19. DECEASED AT Home		20. DECEASED AT Home	
21. DECEASED AT Home		22. DECEASED AT Home		23. DECEASED AT Home		24. DECEASED AT Home		25. DECEASED AT Home	
26. DECEASED AT Home		27. DECEASED AT Home		28. DECEASED AT Home		29. DECEASED AT Home		30. DECEASED AT Home	
31. DECEASED AT Home		32. DECEASED AT Home		33. DECEASED AT Home		34. DECEASED AT Home		35. DECEASED AT Home	
36. DECEASED AT Home		37. DECEASED AT Home		38. DECEASED AT Home		39. DECEASED AT Home		40. DECEASED AT Home	
41. DECEASED AT Home		42. DECEASED AT Home		43. DECEASED AT Home		44. DECEASED AT Home		45. DECEASED AT Home	
46. DECEASED AT Home		47. DECEASED AT Home		48. DECEASED AT Home		49. DECEASED AT Home		50. DECEASED AT Home	
51. DECEASED AT Home		52. DECEASED AT Home		53. DECEASED AT Home		54. DECEASED AT Home		55. DECEASED AT Home	
56. DECEASED AT Home		57. DECEASED AT Home		58. DECEASED AT Home		59. DECEASED AT Home		60. DECEASED AT Home	
61. DECEASED AT Home		62. DECEASED AT Home		63. DECEASED AT Home		64. DECEASED AT Home		65. DECEASED AT Home	
66. DECEASED AT Home		67. DECEASED AT Home		68. DECEASED AT Home		69. DECEASED AT Home		70. DECEASED AT Home	
71. DECEASED AT Home		72. DECEASED AT Home		73. DECEASED AT Home		74. DECEASED AT Home		75. DECEASED AT Home	
76. DECEASED AT Home		77. DECEASED AT Home		78. DECEASED AT Home		79. DECEASED AT Home		80. DECEASED AT Home	
81. DECEASED AT Home		82. DECEASED AT Home		83. DECEASED AT Home		84. DECEASED AT Home		85. DECEASED AT Home	
86. DECEASED AT Home		87. DECEASED AT Home		88. DECEASED AT Home		89. DECEASED AT Home		90. DECEASED AT Home	
91. DECEASED AT Home		92. DECEASED AT Home		93. DECEASED AT Home		94. DECEASED AT Home		95. DECEASED AT Home	
96. DECEASED AT Home		97. DECEASED AT Home		98. DECEASED AT Home		99. DECEASED AT Home		100. DECEASED AT Home	

BUREAU V. S.

AUG 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09004

09013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 64 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 3				d. STREET ADDRESS RFD # 3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillie Middle May Last Ottwell				4. DATE OF DEATH Month Aug. Day 19 Year 19 57							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1893		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Delmar, Md.			
13. FATHER'S NAME Mathias Tingle				14. MOTHER'S MAIDEN NAME Ann Lizzie Workman				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----				17. INFORMANT Address Fred J. Ottwell, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis (c) -----										INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/8 , 19 57 , to death , 19 57 , that I last saw the deceased alive on 8/18 , 19 57 , and that death occurred at 6 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Pine Delmar, Del DATE SIGNED 8/20/57											
ACTUAL SIGNATURE Ernest Z. Larson M.D.				PHYSICIAN'S NAME (Type) E. M. LARMORE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-22-57		22c. NAME OF CEMETERY OR CREMATORY Melsons				22d. LOCATION (City, town, or county) Delmar, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marshall Co - Delmar, Del				ADDRESS -----				24a. REC'D BY REGISTRAR DATE AUG 22 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

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AUG 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

08988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 501 Poplar Hill Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDNA Middle PAYNE Last PAYNE				4. DATE OF DEATH Month AUGUST Day 13 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1887	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 10 Days 5		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R.D. # Salisbury, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Elisha J.C. Parsons				14. MOTHER'S MAIDEN NAME Ella Ennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mr. Ira M. Payne (Husband)			
17. INFORMANT Mr. Ira M. Payne (Husband)				Address 501 Poplar Hill Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 170X DUE TO BREAST CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 years (c) 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INANITION							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/7/57 , 19 57 , to Aug 13 , 19 57 , that I last saw the deceased alive on Aug 13, 19 57 , and that death occurred at 12:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Md DATE SIGNED Aug. 14 1957							
ACTUAL SIGNATURE Dr. O.J. Burton M.D.							
PHYSICIAN'S NAME (Type) Dr. O.J. Burton Maryland Ave. Salisbury, Md Aug. 14 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR Aug 15 1957 REGISTRAR'S SIGNATURE Mary Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08989

CERTIFICATE OF DEATH

Reg. Dist. No.

0900632

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GEN. GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>23002</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mamie A. Powell</u>				4. DATE OF DEATH Month Day Year <u>AUG. 2 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 24, 1880</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>CHINCOTEAGUE VA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CYRUS REED</u>				14. MOTHER'S MAIDEN NAME <u>NANCY BENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS. HOWARD BROWN, OCEAN CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Weeks?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/31</u> , 1957, to <u>8/1</u> , 1957, that I last saw the deceased alive on <u>8/1</u> , 1957, and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>321 S. D.W. ST. SALISBURY, Md.</u>			
DATE SIGNED <u>8/1/57</u>							
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>8/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burby</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary A. Holloway</u>	

BUREAU V. S.

1957 5 AUG

RECEIVED

08990

CERTIFICATE OF DEATH

09007

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 3 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury f. STREET ADDRESS 206 N. Blvd. Springhill Road	
3. NAME OF DECEASED (Type or print) Levin Thomas		4. DATE OF DEATH Month August Day 22 Year 1957.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1880
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Meat	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Price		14. MOTHER'S MAIDEN NAME Amanda Causey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT J. Wm. Price		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic heart disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 8-22, 1957 , to 8-22, 1957 , that I last saw the deceased alive on 8-22, 1957 , and that death occurred at 11:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 402 Camden Ave., Salisbury, Maryland DATE SIGNED 8-23-57			
ACTUAL SIGNATURE Earl Royer		M.D.	
PHYSICIAN'S NAME (Type) Earl Royer		402 Camden Ave., Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/24/1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR DATE 8-23-57		24b. REGISTRAR'S SIGNATURE Marshall Holman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08991

CERTIFICATE OF DEATH

09008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> 23x2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Bay Road</u>	
3. NAME OF DECEASED (Type or print) <u>Milton</u> First <u>C.</u> Middle <u>Riggin</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1885</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Columbus Riggin</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Patterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs Phemie E. Riggin, Stockton, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal Hemorrhage</u> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Lymphocytic Leukemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 25, 1957</u> , to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 25, 1957</u> , and that death occurred at <u>5:21</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>224 N. Division St.</u>	
DATE SIGNED <u>Aug 29 1957</u>		DATE SIGNED <u>Mary J. Holloway</u>	
18. FATHER'S NAME <u>Columbus Riggin</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Patterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs Phemie E. Riggin, Stockton, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal Hemorrhage</u> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Lymphocytic Leukemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 25, 1957</u> , to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 25, 1957</u> , and that death occurred at <u>5:21</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>224 N. Division St.</u>	
DATE SIGNED <u>Aug 29 1957</u>		DATE SIGNED <u>Mary J. Holloway</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>		ADDRESS <u>Pocomoke, Md.</u>	
24a. RECEIVED BY REGISTRAR <u>Aug 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

RECEIVED
AUG 22 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08992

CERTIFICATE OF DEATH

09009

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2mo. 3 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1011 S. Sharp St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle -- Last Rozell				4. DATE OF DEATH Month August Day 26 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1903	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Rozell				14. MOTHER'S MAIDEN NAME Susan McDowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT Deer's Head State Hospital, Salisbury, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with advanced metastasis DUE TO 177x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 177x DUE TO (c) 177x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 177x INTERVAL BETWEEN ONSET AND DEATH Unk.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 5, 1957, Aug. 26th, 1957 , that I last saw the deceased alive on August 26th, 1957 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/27/57 ACTUAL SIGNATURE M. V. Juerman M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) V. Juerman, M. D. Deer's Head State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/31/57			
22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM. BALTO. Md.				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE ISAIAH L. BROWN & SON 108 W. MONTGOMERY ST.				24a. REC'D BY REGISTRAR DATE 9/3/57			
24b. REGISTRAR'S SIGNATURE Mary H. Hall							

CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. MARITAL STATUS [REDACTED]</p>		<p>12. EDUCATION [REDACTED]</p>	
<p>13. PREVIOUS ILLNESS [REDACTED]</p>		<p>14. MEDICAL HISTORY [REDACTED]</p>		<p>15. PHYSICIAN'S SIGNATURE [REDACTED]</p>	
<p>16. CORONER'S SIGNATURE [REDACTED]</p>		<p>17. COUNTY CLERK'S SIGNATURE [REDACTED]</p>		<p>18. MUNICIPAL CLERK'S SIGNATURE [REDACTED]</p>	

BUREAU V. 3

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08993

CERTIFICATE OF DEATH

Reg. Dist. No.

09010

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>PEMBERTON</u> 1	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruark</u>		4. DATE OF DEATH Month <u>August</u> Day <u>2nd</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2nd 57</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) <u>30</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Billy WALLACE Ruark</u>		14. MOTHER'S MAIDEN NAME <u>IRMA Lee WALKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 20 weeks.</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature labor - etiology unknown.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from, 19, to, 19, that I last saw the deceased alive on, 19, and that death occurred at <u>8</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stedman W. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>8-3-57</u>	
PHYSICIAN'S NAME (Type) <u>Stedman W. Smith, M.D., Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-3-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>8-3-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Marjorie Holloman</u>	

2082346XVO

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
MAYNARD		MALE		35		JAN 15 1922	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
AUG 5 1957		BALTIMORE, MD		10:00 PM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
AUG 6 1957		AUG 6 1957		AUG 6 1957		AUG 6 1957	

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08994
CERTIFICATE OF DEATH

09011

Reg. Dist. No. 322

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 1/2 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Humphrey Last Ruark		4. DATE OF DEATH Month August Day 29 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1895
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Machine Repairman		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sidney H. Ruark		14. MOTHER'S MAIDEN NAME Martha E. Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NOX Yes --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Deer's Head State Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis of Ca. of Esophagus 150x DUE TO -- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) -- DUE TO -- (c) --		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5, 1957 , to Aug. 29, 1957 , that I last saw the deceased alive on August 29th, 1957 , and that death occurred at 9:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/30/57 ACTUAL SIGNATURE G. Kosmahly M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) G. Kosmahly, M.D. Deer's Head State Hospital, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 1st, 1957	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REG'D BY REGISTRAR SEP 3 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08995

CERTIFICATE OF DEATH

0901231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Shoemaker Road - RFD #2</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Alonzo</u> Middle <u>Shockley</u> Last <u>Shockley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1957</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15, 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Stanbury Shockley</u>			14. MOTHER'S MAIDEN NAME <u>Lizzie Townsend</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mr. Robert Shockley - 5709 N. 16th St. Philadelphia Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary Thrombosis & embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I attended the deceased from <u>8/17/57</u> , 19____, to <u>8/23/57</u> , 19____, that I last saw the deceased alive on <u>8/23/57</u> , 19____, and that death occurred at <u>8:55 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Dr. Carlel Hearn</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DR. CARLEL HEARN</u> <u>226 A Division St</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug 29, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES, Therman Park</u>	22d. LOCATION (City, town, or county) <u>Salisbury</u> (State) <u>md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>		ADDRESS <u>FUNERAL HOME, Salisbury, Md.</u>		24. REC'D BY REGISTRAR <u>AUG 30 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		

RECEIVED
AUG 30 1957
BUREAU V. S.

Name of Deceased		Sex	
Age		Date of Birth	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Date of Death		Time of Death	
Place of Death		Hospital or Institution	
Signature of Registrar		Signature of Coroner	
Date of Registration		Time of Registration	
Place of Registration		Signature of Registrar	

09014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Shad Point)		d. STREET ADDRESS R.D.# 1 (Shad Point)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle FRANCH Last SMITH		4. DATE OF DEATH Month AUGUST Day 30 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1878
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Boats	
11. BIRTHPLACE (State or foreign country) R.D.# 1 Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William W. Smith		14. MOTHER'S MAIDEN NAME Theodosia Disharoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Nancy E. Smith (Wife) Address R.D.# 1 (Shad Point) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO CHD pulmonale. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary tuberculosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 2 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/19 , 19 57 , to 8/30 , 19 57 , that I last saw the deceased alive on 8/29 , 19 57 , and that death occurred at 6:58 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Aug. 3/1/57			
ACTUAL SIGNATURE Earl M. Beardsley		M.D. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley		Maryland Ave. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery	22d. LOCATION (City, town, or county) (State) Parsonsbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS 	
24a. REC'D BY REGISTRAR SEP 3 1957		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	

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CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH JAN 10 1957	
5. PLACE OF DEATH Home		6. COUNTY Baltimore		7. CITY Baltimore		8. STATE Maryland	
9. OCCUPATION Retired		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF DECEASED (None)	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF WITNESSES J. H. HARRIS		15. SIGNATURE OF REGISTRAR J. H. HARRIS		16. SIGNATURE OF CLERK J. H. HARRIS	
17. SIGNATURE OF DECEASED (None)		18. SIGNATURE OF PHYSICIAN J. H. HARRIS		19. SIGNATURE OF WITNESSES J. H. HARRIS		20. SIGNATURE OF REGISTRAR J. H. HARRIS	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF PHYSICIAN J. H. HARRIS		23. SIGNATURE OF WITNESSES J. H. HARRIS		24. SIGNATURE OF REGISTRAR J. H. HARRIS	
25. SIGNATURE OF DECEASED (None)		26. SIGNATURE OF PHYSICIAN J. H. HARRIS		27. SIGNATURE OF WITNESSES J. H. HARRIS		28. SIGNATURE OF REGISTRAR J. H. HARRIS	
29. SIGNATURE OF DECEASED (None)		30. SIGNATURE OF PHYSICIAN J. H. HARRIS		31. SIGNATURE OF WITNESSES J. H. HARRIS		32. SIGNATURE OF REGISTRAR J. H. HARRIS	
33. SIGNATURE OF DECEASED (None)		34. SIGNATURE OF PHYSICIAN J. H. HARRIS		35. SIGNATURE OF WITNESSES J. H. HARRIS		36. SIGNATURE OF REGISTRAR J. H. HARRIS	
37. SIGNATURE OF DECEASED (None)		38. SIGNATURE OF PHYSICIAN J. H. HARRIS		39. SIGNATURE OF WITNESSES J. H. HARRIS		40. SIGNATURE OF REGISTRAR J. H. HARRIS	
41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF PHYSICIAN J. H. HARRIS		43. SIGNATURE OF WITNESSES J. H. HARRIS		44. SIGNATURE OF REGISTRAR J. H. HARRIS	
45. SIGNATURE OF DECEASED (None)		46. SIGNATURE OF PHYSICIAN J. H. HARRIS		47. SIGNATURE OF WITNESSES J. H. HARRIS		48. SIGNATURE OF REGISTRAR J. H. HARRIS	
49. SIGNATURE OF DECEASED (None)		50. SIGNATURE OF PHYSICIAN J. H. HARRIS		51. SIGNATURE OF WITNESSES J. H. HARRIS		52. SIGNATURE OF REGISTRAR J. H. HARRIS	
53. SIGNATURE OF DECEASED (None)		54. SIGNATURE OF PHYSICIAN J. H. HARRIS		55. SIGNATURE OF WITNESSES J. H. HARRIS		56. SIGNATURE OF REGISTRAR J. H. HARRIS	
57. SIGNATURE OF DECEASED (None)		58. SIGNATURE OF PHYSICIAN J. H. HARRIS		59. SIGNATURE OF WITNESSES J. H. HARRIS		60. SIGNATURE OF REGISTRAR J. H. HARRIS	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF PHYSICIAN J. H. HARRIS		63. SIGNATURE OF WITNESSES J. H. HARRIS		64. SIGNATURE OF REGISTRAR J. H. HARRIS	
65. SIGNATURE OF DECEASED (None)		66. SIGNATURE OF PHYSICIAN J. H. HARRIS		67. SIGNATURE OF WITNESSES J. H. HARRIS		68. SIGNATURE OF REGISTRAR J. H. HARRIS	
69. SIGNATURE OF DECEASED (None)		70. SIGNATURE OF PHYSICIAN J. H. HARRIS		71. SIGNATURE OF WITNESSES J. H. HARRIS		72. SIGNATURE OF REGISTRAR J. H. HARRIS	
73. SIGNATURE OF DECEASED (None)		74. SIGNATURE OF PHYSICIAN J. H. HARRIS		75. SIGNATURE OF WITNESSES J. H. HARRIS		76. SIGNATURE OF REGISTRAR J. H. HARRIS	
77. SIGNATURE OF DECEASED (None)		78. SIGNATURE OF PHYSICIAN J. H. HARRIS		79. SIGNATURE OF WITNESSES J. H. HARRIS		80. SIGNATURE OF REGISTRAR J. H. HARRIS	
81. SIGNATURE OF DECEASED (None)		82. SIGNATURE OF PHYSICIAN J. H. HARRIS		83. SIGNATURE OF WITNESSES J. H. HARRIS		84. SIGNATURE OF REGISTRAR J. H. HARRIS	
85. SIGNATURE OF DECEASED (None)		86. SIGNATURE OF PHYSICIAN J. H. HARRIS		87. SIGNATURE OF WITNESSES J. H. HARRIS		88. SIGNATURE OF REGISTRAR J. H. HARRIS	
89. SIGNATURE OF DECEASED (None)		90. SIGNATURE OF PHYSICIAN J. H. HARRIS		91. SIGNATURE OF WITNESSES J. H. HARRIS		92. SIGNATURE OF REGISTRAR J. H. HARRIS	
93. SIGNATURE OF DECEASED (None)		94. SIGNATURE OF PHYSICIAN J. H. HARRIS		95. SIGNATURE OF WITNESSES J. H. HARRIS		96. SIGNATURE OF REGISTRAR J. H. HARRIS	
97. SIGNATURE OF DECEASED (None)		98. SIGNATURE OF PHYSICIAN J. H. HARRIS		99. SIGNATURE OF WITNESSES J. H. HARRIS		100. SIGNATURE OF REGISTRAR J. H. HARRIS	

BUREAU V. 1

SEP 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08996

CERTIFICATE OF DEATH

090143 ✓
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 35 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Box 55			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Reynolds Middle -- Last SMITH				4. DATE OF DEATH Month August Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1901	
				9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman				10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Danville, Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Smith				14. MOTHER'S MAIDEN NAME Lena Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Hospital Records, Deer's Head Hospital Salisbury, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO 145x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous cell Carcinoma of left tonsil with metastasis DUE TO (c) 1 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 12, 1957 , to August 12, 1957 , that I last saw the deceased alive on August 12, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/12/57							
ACTUAL SIGNATURE Dr. Juerman				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-15-57		22c. NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) NEWBERRY Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Malvan & Schey 424 R St N				24a. REC'D BY REGISTRAR DATE 15 1957		24b. REGISTRAR'S SIGNATURE Mary Hall	

CERTIFICATE OF DEATH

1957

CHARLES

MARYLAND

PLACE OF DEATH

DATE OF DEATH



NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

BUREAU V. S.

AUG 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09015 335

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardella Springs x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS R.F.D.1 Box 74		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lannie William Stanley				4. DATE OF DEATH Month Day Year 8 11 1957			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/15/13	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory, Basket		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Handy Stanley				14. MOTHER'S MAIDEN NAME Ida S. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-6043		17. INFORMANT Address Mrs. Margie Stanley, Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon-monoxide poisoning. 9773.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/57		22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		22d. LOCATION (City, town, or county) (State) Mardella Springs, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.				24a. REC'D BY REGISTRAR AUG 15 1957			
				24b. REGISTRAR'S SIGNATURE Mary Owens			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Witnesses		Physician		Nurse	
Funeral Home		Burial Place		Date of Burial	
Remarks		Remarks		Remarks	

BUREAU V. S.

AUG 15 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09016

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Monomaco</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boulevard Theatre</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md.</u> d. STREET ADDRESS <u>311 Broad St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Alfred Stevens</u>		4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>ee</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-02</u>
9. AGE (In years) <u>54</u> <u>35</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>19</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		12. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
13. BIRTHPLACE (State or foreign country) <u>Onancock Va</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>?</u>		16. MOTHER'S MAIDEN NAME <u>Gerelle Braxton</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u>230-072116</u>	
19. INFORMANT <u>Bettie Stevens</u>		Address <u>Onancock, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Lft coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gaynes Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Onancock Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Becker</u>		24a. REC'D BY REGISTRAR <u>AUG 14 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>	

0-30

BUREAU V. S.

AUG 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08998

CERTIFICATE OF DEATH

09017

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEIN GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jerome Westley Strader</u>		4. DATE OF DEATH Month Day Year <u>August 3 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5, 1877</u>
9. AGE (In years lost birth day) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT CLERK</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
13. FATHER'S NAME <u>JOHN W. STRADER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year for dates of service) <u>No</u>		17. INFORMANT <u>MR. EARL E. CONLEY</u> Address <u>OGAN CITY, MD</u>	
16. SOCIAL SECURITY NO. <u>213-16-7674</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>57</u> , to <u>Aug 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 3</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>Aug. 3, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u>		24a. REC'D BY REGISTRAR <u>Aug 6 1957</u>	
ADDRESS <u>Berlin Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>	

BUREAU V. S.

6 AUG 1957

RECEIVED

08999

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN IB 14 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Route # 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rita Middle E. Last Tubbs				4. DATE OF DEATH Month August Day 5 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/1887		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland Whaleyville,		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Tubbs				14. MOTHER'S MAIDEN NAME Ellen Wainwright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. no		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Record Address Myella Short Route #1 Snow Hill, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of pancreas DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH ?
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 4 , 19 56 , to August 5 , 19 57 , that I last saw the deceased alive on August 5 , 19 57 , and that death occurred at 10 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 8/5/57							
ACTUAL SIGNATURE L. V. Maldve M.D.				DEER'S HEAD STATE HOSPITAL			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/5/57		Gregory Cemetery		Berlin	
23. FUNERAL DIRECTOR'S SIGNATURE Elaine E. Dennis				ADDRESS Snow Hill, Md		24a. REC'D BY REGISTRAR Aug 7 1957	
						24b. REGISTRAR'S SIGNATURE Mary H. Hollway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE 12

7 AUG 1957

RECEIVED

09000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS 418 W. College Ave.	
3. NAME OF DECEASED (Type or print) First NORA Middle B Last WATSON		4. DATE OF DEATH Month AUGUST Day 28th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27th, 1927
9. AGE (In years last birthday) 28		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R. D. # Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Theodorus Thomas Bailey		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. L.J. Bayard (Daughter) 418 W. College Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Cardiac Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 7, 1957 to August 28, 1957 , that I last saw the deceased alive on August 28, 1957 , and that death occurred at 4:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas C. Hill		M.D.	
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill		N. Division St. Salisbury, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 slip, shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 3 1957

RECEIVED

SEP 3 1957

BUREAU V. 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE, MD.
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
CITY OF RESIDENCE: [illegible]
CITY OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]
SIGNATURE OF JUDGE: [illegible]
SIGNATURE OF CLERK: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09001
CERTIFICATE OF DEATH

09020
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 4 WEEKS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GALESTOWN		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 BROOKLYN AVE.	
d. STREET ADDRESS RD #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GILBERT Middle MADISON Last WHEATLEY		4. DATE OF DEATH Month AUG Day 28 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 12, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CURTIS T. WHEATLEY		14. MOTHER'S MAIDEN NAME REBECCA PAYNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT NORAC WHEATLEY Address RD #3 SEAFORD DEL.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10, 1957 , to 8/26, 1957 , that I last saw the deceased alive on Aug. 27, 1957 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Del. DATE SIGNED Aug. 30, 1957 ACTUAL SIGNATURE David J. Gilmore M.D. PHYSICIAN'S NAME (Type) DAVID J. GILMORE SALISBURY, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 1, 1957	
22c. NAME OF CEMETERY OR CREMATORY COKEBURY CEMETERY		22d. LOCATION (City, town, or county) (State) COKEBURY MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE MEDFORD L. WATSON ADDRESS SEAFORD, DEL		24. REG'D BY REGISTRAR SEP 3 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

Reg. Dist. No.

09021332

09002

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE</u>			
c. LENGTH OF STAY IN 1b <u>1 DAY</u>				d. STREET ADDRESS <u>608 SECOND STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BELLE</u> Middle <u>T.</u> Last <u>WHYTE</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 83</u>	
9. AGE (In years last birthday) <u>UNKN.</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ALFRED BELL TURPIN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS KENNETH W. COLE, EVANSTON, ILL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>and Hypertension.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 28, 1957</u> , to <u>August 30, 1957</u> , that I last saw the deceased alive on <u>August 30, 1957</u> , and that death occurred at <u>3:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>224 N. Division St.</u> DATE SIGNED <u>8/30/57</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR.</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EPISCOPAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u> ADDRESS <u>POCOMOKE, MD.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 3 1957

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The text is mirrored and mostly illegible due to the quality of the scan.

BUREAU V. 8

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09903 CERTIFICATE OF DEATH

Reg. Dist. No. 332

09022

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Kentucky</u> b. COUNTY <u>Jefferson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 Hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>2082 Douglas Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First <u>JUDITH</u> Middle <u>WILEY</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elementary</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ernest J. Wiley</u>		14. MOTHER'S MAIDEN NAME <u>Tillie Fischal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Matilda Wiley, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> (c) <u>Diseases</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-26, 1957</u> , to <u>8-26, 1957</u> , that I last saw the deceased alive on <u>8-26, 1957</u> , and that death occurred at <u>1:15 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm B. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>8/26/1957</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William Smith Medical Center Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Adath Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Louisville, Ky.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Baker</u>				ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>8-27-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holladay</u>			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10/15/1890</u></p>		<p>4. Place of birth: <u>NEW YORK, N.Y.</u></p>	
<p>5. Date of death: <u>8/10/1957</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>8/15/1957</u></p>		<p>12. Place of registration: <u>BALTIMORE, MD.</u></p>	

BUREAU V. 3

AUG 29 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 090233											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 333 Catherine Street (Private home)						d. STREET ADDRESS 333 Catherine St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Armenus Middle Williams Last Williams						4. DATE OF DEATH Month 8 Day 19 Year 57					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1898		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Noah T. Williams						14. MOTHER'S MAIDEN NAME Lucretia Barclay					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 214-10-7392		17. INFORMANT Address Mrs. Margie Williams: 333 Catherine St. City					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Edema of the brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic alcoholism DUE TO (c) 322.1										INTERVAL BETWEEN ONSET AND DEATH Sudden Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Salisbury		(County) Wicomico		(State) Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Naturol causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Earl L. Royer, M.D.						DATE SIGNED 8-23-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8-23-57		22c. NAME OF CEMETERY OR CREMATORY Green Acre Memorial Park			22d. LOCATION (City, town, or county) (State) Salisbury, Md			
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md						ADDRESS Salisbury, Md		24a. REC'D BY REGISTRAR AUG 27 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TOP STATE
HEALTH DIST

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

AUG -27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09024
 09005 CERTIFICATE OF DEATH 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> Snow Hill 23 X 0-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W.D. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George M. Williams</u>		4. DATE OF DEATH Month Day Year <u>August 24 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22/1957</u>
9. AGE (In years lost birth day) <u>1</u> yrs. <u>23</u> months <u>55</u> days		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11c. BIRTH PLACE (State or foreign country) <u>Salisbury, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Williams</u>		14. MOTHER'S MAIDEN NAME <u>Jane Pethman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Matthe Pethman</u>		Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>7620</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Edema and Congestion of Brain</u> DUE TO <u>Fetal Anoxia</u> (c) <u>2 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia (Terminal)</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/22</u> , 1957, to <u>8/24</u> , 1957, that I last saw the deceased alive on <u>8/23</u> , 1957, and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>8/24/57</u>			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Aug 25/57</u>		22b. DATE THEREOF <u>Aug 25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Dennis</u>		24a. REC'D BY REGISTRAR <u>Aug 25 1957</u>	
ADDRESS <u>Snow Hill, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollenback</u>	

AUG 27 1957

RECEIVED

09006

CERTIFICATE OF DEATH

Reg. Dist. No.

09025

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL 23X2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>114 IRONSHIRE ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD H. WILSON</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 28 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20 - 1914</u>	
9. AGE (In years last birthday) <u>43</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing, Heating Contractor own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto W. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Ebna Shackley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. Coast Guard, World War II</u>				16. SOCIAL SECURITY NO. <u>213-01-7577</u>			
17. INFORMANT <u>Mrs Dorothy H. Wilson</u>				Address <u>Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular</u> DUE TO disease (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 30 1957</u>		<u>Whitcomb Cemetery</u>		<u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way B. Dennis</u>				ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR DATE <u>30 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Edwards</u>							

BUREAU V. 3

AUG 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09007
CERTIFICATE OF DEATH

09026
337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 3 1/2 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31, Maryland		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 35 N. Eden Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Elizabeth Last Wilson		4. DATE OF DEATH Month August Day 19 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1910
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Brown		14. MOTHER'S MAIDEN NAME Sadie Rome	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. --	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease, decompensated DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis, chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 18, 1954 , to August 19, 1957 , that I last saw the deceased alive on August 19, 1957 , and that death occurred at 4:32 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/20/57			
ACTUAL SIGNATURE Dr. V. Juerman M.D.		PHYSICIAN'S NAME (Type) V. Juerman, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Eroy D. Wilson		24a. REC'D BY REGISTRAR AUG 22 1957	
ADDRESS 1000 Brantley Ave.		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

AUG 22 1957

RECEIVED

09016

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BENJIMAN Middle WRIGHT Last				4. DATE OF DEATH Month August Day 17 Year 19 57			
5. SEX Male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oyster tonger		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Stewart Wright				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Stewart Wright, Jesterville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 27 April 1947 to 17 August 1957 , that I last saw the deceased alive on 17 August 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nanticoke Md. DATE SIGNED 8/19/57							
ACTUAL SIGNATURE Richard H. Saunders M.D.				DATE SIGNED 8/19/57			
PHYSICIAN'S NAME (Type) Richard H. Saunders				ADDRESS Nanticoke, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57		22c. NAME OF CEMETERY OR CREMATORY Jesterville Cem.		22d. LOCATION (City, town, or county) (State) Jesterville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messick				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR AUG 27 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

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